

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-036018

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

318#21778336 SL#27128

1003

9370

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Register District No.

Primary Registration District No.

Registrar's No.

9370

FILED OCT 1 1962

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		Length of stay in 1b 62 DAYS	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VAH, ST. LOUIS, MO.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last PAUL CAULFIELD		4. DATE OF DEATH Month Day Year SEPTEMBER 28 1962	
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH 10/25/96
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOSPITAL ATTENDANT		10b. KIND OF BUSINESS OR INDUSTRY -----	11. BIRTHPLACE (City and state or country) ST. LOUIS, MO.
13a. FATHER'S NAME PATRICK CAULFIELD		13b. MOTHER'S MAIDEN NAME PAULINE SHERMAN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WW I		17. INFORMANT Address JAMES CAULFIELD (BRO) 505 WASH. STL. MO.	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) WIDESPREAD CARCINOMATOSIS DUE TO (b) CARCINOMA OF PROSTATE DUE TO (c) 177X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21. attended the deceased from 7/24/62 to 9/28/62 and last saw him alive on 9/28/62 Death occurred at 5:10 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.		22b. ADDRESS VAH, ST. LOUIS, MO.	
22a. SIGNATURE Gordon W. Pluffott M.D.		22c. DATE SIGNED 9/28/62	
23a. BURIAL, CREMATION, REMOVAL (Specify) removal		23b. DATE 10/3/62	
23c. NAME OF CEMETERY OR CREMATORY National Cem.		23d. LOCATION (City, town, or county) (State) Jefferson Bks. Mo	
24. FUNERAL DIRECTOR Edward Fendler 5611 South Grand Blvd.		25. DATE RECD. BY LOCAL REG. OCT 1 1962	
26. REGISTRAR'S SIGNATURE Road Smith MO			

USE BLACK INK
OR
TYPEWRITER RIBBON

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Leo J. Bunker

Licensed Embalmer No. 3989

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.